



**BUREAU OF ECONOMIC SECURITY**  
**MEDICAID**  
**MEDICALLY FRAIL CERTIFICATION FORM**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

CASE NUMBER: \_\_\_\_\_

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As part of the enrollment process in the New Adult Group Plan, Guam Medicaid Program must identify individuals who have enhanced medical needs as identified in 42 CFR §440.315(f) and offer them the choice of coverage between the Medicaid State Plan and the Alternative Benefit Plan.

Federal law defines individuals who are exempt from mandatory enrollment in the Guam Medicaid New Adult Group Plan as:

“Medically Frail” 42 CFR §440.315(f): includes individuals with disabling mental disorders (including adults with serious mental illness) individuals with chronic substance use disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living, or individuals with a disability determination based on Social Security criteria.

If you or a member of your household meets the definition of Medically Frail above, please check ALL the appropriate boxes below that best defines the medical condition	
1. Individuals with disabling mental disorder and has a diagnosis of at least one of the following:	
<input type="checkbox"/>	Psychotic disorder
<input type="checkbox"/>	Schizophrenia
<input type="checkbox"/>	Schizoaffective disorder
<input type="checkbox"/>	Major depression
<input type="checkbox"/>	Bipolar disorder
<input type="checkbox"/>	Delusional disorder
<input type="checkbox"/>	Obsessive-compulsive disorder
2. Individuals with chronic substance use disorder of the following:	
<input type="checkbox"/>	A diagnosis of substance use disorder, AND
<input type="checkbox"/>	Meets the severe substance abuse disorder level on the DSM-V Severity Scale by meeting 6 or more diagnostic criteria, OR
<input type="checkbox"/>	Current condition meets the medically-monitored or medically-managed intensive inpatient criteria of the ASAM criteria. <i>("DSM-V" means the 5<sup>th</sup> edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. ("ASAM criteria" means the 2013 edition of the ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and co-Occurring Conditions published by the American Society of Addiction Medicine.)</i>
3. Individuals with serious and complex medical conditions of the following:	
<input type="checkbox"/>	Meets criteria for hospice services, OR
<input type="checkbox"/>	Has a serious and complex medical condition, OR
<input type="checkbox"/>	Condition significantly impairs the ability to perform one or more activities of daily living (ADLs) <b>(Go to Box 7 to describe the impairment in ability to perform ADLs).</b>
4. Individuals with physical disability of the following:	
<input type="checkbox"/>	Has a physical disability AND
<input type="checkbox"/>	Condition significantly impairs the ability to perform one or more activities of daily living (ADLs) <b>(Go to Box 7 to describe the impairment in ability to perform ADLs).</b>

5. Individuals with an intellectual or developmental disability defined as a severe, chronic disability that:
- Is attributable to a mental or physical impairment or combination of mental and physical impairments;
  - Is manifested before the age of 22;
  - Is likely to continue indefinitely;
  - Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and
  - Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.
  - The condition significantly impairs the ability to perform one or more activities of daily living (ADLs)\* (see below for details on ADLs). **(Go to Box 7 to describe the impairment in ability to perform ADLs).**

6. Individuals with a disability determination

- The individual has a current disability designation by the Social Security Administration.

**Use the box below to describe the activities of daily living (ADLs) the member needs assistance with and the frequency of that need.**

**(Examples of ADLs may include but are not limited to bathing and showering, bowel and bladder management, dressing, eating, feeding, functional mobility, personal device care, personal hygiene and grooming and/or toilet hygiene.)**

7.

**PROVIDER/REFERRING ENTITY INFORMATION**

Provider/Entity Agency or Facility Name:

Provider/Entity Personnel Name:

\_\_\_\_\_  
(Please Print)

\_\_\_\_\_  
(Please Print)

Provider/Entity Signature:

Telephone Number:

\_\_\_\_\_  
Provider NPI #:

\_\_\_\_\_  
Provider Email Address:

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APPLICANT VOLUNTARY ENROLLMENT/DISENROLLMENT STATUS (Please select only one):

New Adult Benefit Plan

Medicaid Program Plan

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APPLICANT ATTESTATION AND SIGNATURE/DATE:

*I certify that the aforementioned information is true and accurate, and I understand that any falsification, omission, or concealment of material fact may subject me to disqualification or termination from the program. I also give consent for enrollment in the selected Alternative Benefit Plan.*

Signature: \_\_\_\_\_

Date: \_\_\_\_\_